COLORADO

MEDICAL ASSISTANCE PROGRAM

STANDARD PROVIDER APPLICATION

Fiscal Agent for the
Colorado Medical Assistance Program

ACS
A xerox Company

PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or 1-800-237-0044
colorado.gov/hcpf

Table of Contents

Change of Ownership or Change of Tax ID Number

All applicants must complete

Providers are reminded that a change of ownership or a change of tax ID number terminates the Medical Assistance Program Provider participation agreement. New owners and providers with **new tax ID numbers** must re-apply and complete a new Medical Assistance Program Provider Participation Agreement in order to participate in the Colorado Medical Assistance Program.

1 Change of Ownership Information

Is this application the result of a change of ownership or a change of tax ID number?	No ☐ Yes ☐
Did you purchase this business or practice from an enrolled Colorado Medical Assistance Program provider?	No ☐ Yes ☐

If no, sign and submit this form with your application.

If yes, you must complete the following information.

Enter the name and Colorado Medical Assistance Program provider number of the closing (selling) provider.

If you have a new tax ID number and still own your company, enter the name and Medical Assistance Program provider number associated with your old tax ID number.

Name: _____ Provider number: _____

Effective date of change of ownership or change of tax ID number: ____/____/_____

If this is a Change of Ownership, we **must** receive a statement from the closing (selling) provider including:

- The name of the opening (purchasing) provider,
- The effective date of the change of ownership, and
- A forwarding address.

If this information is not provided, your application will not be processed.

You may not submit claims for dates of service before your application is activated.

In addition, while your application is in process, you may not submit claims using:

- The closing provider's Colorado Medical Assistance Program provider number or
- The Colorado Medical Assistance Program provider number associated with your old tax ID number.

Signature and date

All providers must sign and date

_____ _____

Provider Signature **Date**

Name and Business Organization Information

All applicants must complete

Providers must enroll as either an Individual <u>or</u> a Business

2 Name and Type of Business Practice

Individuals (Applying under Social Security #)

Individual practitioners must enroll using the name shown on their social security card. If payments for services are to be made to a group practice, partnership, or corporation, then the group, partnership, or corporation must enroll and obtain a Medical Assistance Program provider number to be used for submitting claims as the billing provider. All individual practitioners who render services must be enrolled.

Individuals Last Name	First Name	M.I.	Title/Degree

Business ventures (sole proprietors, groups, partnerships, and corporations) (Applying under a Tax ID)

Legal business name (exactly as registered with the Internal Revenue Service)

Doing Business As (DBA) name (if applicable)

Mark the applicable type of business:

O Partnership O Limited Liability Partner O Sole Proprietor O Other

O Trust O Government Agency O Corporation

Institutions (Hospitals)

Legal business name (exactly as registered with the Internal Revenue Service)

Doing Business As (DBA) name (if applicable)

Mark the applicable type of business:

O Partnership O Limited Liability Partner O Sole Proprietor O Other

O Trust O Government Agency O Corporation

Indicate the type of control of the facility (please check one)

O State O Federal O Indian Health Center O Other

Please check if you have seen Colorado Medical Assistance clients within the past 120 days ☐

This space for fiscal agent use

All applicants who will receive direct reimbursement must complete

3	Verification of Lawful Presence in the United States	**Individuals** **Please refer to the Department of Revenue's Web site at http://www.colorado.gov/revenue ➡Library ➡Evidence of Lawful Presence: HB06S-1023 for further information.** **Each individual provider applicant who is 18 years of age or older *who will receive direct reimbursement* must attach a photocopy of one of the following documentation types AND sign the following affidavit** Pursuant to C.R.S. § 24-76.5-103, on or after August 1, 2006, each agency or political subdivision of the State shall verify the lawful presence in the United States of each natural person eighteen years of age or older who applies for state or local public benefits or for federal public benefits by requiring the applicant to produce one of the following: 1) A valid Colorado driver's license or a Colorado identification card; or 2) A United States military card or a military dependent's identification card; or 3) A United States Coast Guard Merchant Mariner card; or 4) A Native American Tribal Document AND Execute the affidavit below.

AFFIDAVIT

for the Colorado Department of Health Care Policy and Financing as Proof of Lawful Presence in the United States

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

__ I am a United States citizen.

__ I am not a United States citizen but I am a Permanent Resident of the United States.

__ I am not a United States citizen but I am lawfully present in the United States pursuant to Federal law.

__ I am a foreign national not physically present in the United States.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature **Date**

Name (please print) Social Security Number

Provider Address Information

All applicants must complete

4 Service Location Address & Phone Information

All applicants must complete. Provide the street address of the location where services will be rendered.

Street address (must be street address)

City | County | State | Zip

( ) Voice Telephone number ( ) Fax Telephone number

5 Billing Office Address & Phone Information

Complete the following information if the billing office address is different from service location address. Payments (if any) made under the assigned provider number will be sent to this address if different from the service location address.

Street address, PO Box

City | County | State | Zip

( ) Voice Telephone number ( ) Fax Telephone number

Business e-mail address:

6 Mailing Address & Phone Information

Complete the following information if the mailing office address is different from service location and billing addresses. Special mailings (if any) made under the assigned provider number will be sent to this address if different from the service location and billing addresses.

Street address, PO Box

City | County | State | Zip

( ) Voice Telephone number ( ) Fax Telephone number

Business e-mail address:

All providers must complete the Payment Reporting and Publication Preferences page (page 21 of this application).

7 Faxback Eligibility Telephone Number

Faxback eligibility allows providers to verify eligibility by telephone and, after hearing the information spoken, receive a fax with the information. If you wish to use this service, your fax telephone number must be recorded on your provider enrollment record. Please identify the telephone number where the faxback eligibility report should be sent. Only a single faxback number can be recorded.

Faxback telephone number ( )

Provider/Submitter Electronic Information

All applicants submitting claims or retrieving reports electronically must complete

Colorado Medical Assistance Program rules (8.040.2) require the electronic submission of claims except in certain circumstances. Providers may also retrieve reports electronically. In order to electronically submit claims, or electronically retrieve reports, applicants must complete these sections.

8 Please indicate how you plan to submit your electronic transactions

Electronic Transactions

- ☐ Vendor Software
- ☐ Billing Agent
- ☐ Clearinghouse/Switch Vendor
- ☒ State's Provider Web Portal

Transactions available for transmission

- ☒ X12N 270 (Eligibility Inquiry)
- ☒ X12N 276 (Claim Status Inquiry)
- ☒ X12N 278 (Prior Authorization)
- ☒ X12N 837P (Professional Claim)
- ☒ X12N 837D (Dental Claim)
- ☒ X12N 837I (Institutional Claim)

9 Electronic Report/ Response Retrieval

If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your 5-digit Submitter ID or 6-digit Trading Partner ID.

☐☐☐☐☐☐

All software vendors must have their own uniquely assigned Submitter or Trading Partner ID to act on your behalf. Please contact your software vendor to confirm their status. Please enter your software vendor's 5-digit Submitter ID or 6-digit Trading Partner ID.

☐☐☐☐☐☐

Software Product _____

Transactions Available for Receiving Reports

Colorado Medical Assistance Program providers can receive X12N electronic reports. Please select the reports that you want to receive through the State's Provider Web Portal. *Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report.*

- ☒ X12N 824 (Payer Specific Error Report) will by default be returned to submitting TP ID
- ☒ X12N 271 (Eligibility Response) will by default be returned to submitting TP ID
- ☒ X12N 997 (Acknowledgement of a sent transaction) will by default be returned to submitting TP ID
- ☒ X12N 277 (Claim Status Response) will by default be returned to submitting TP ID

If the Receiving TP ID field is left blank, it will by default be returned to submitting provider's TP ID

	Receiving TP ID		Receiving TP ID
☐ X12N 820 (Client Capitation)		☐ X12N 835 (Claim payment/Claim report	
☒ Accept/Reject Report			
☐ PCP Roster		☒ Provider Claim Report (Previously called the Remittance Advice Report)	
☐ X12N 834 (Benefit Enrollment and Maintenance)		☐ Managed Care Transactions	
☒ PAR Letters		☐ ACC Roster Report	

Element Delimiter to be used: ☐ Default Delimiter (asterisk) *****

Sub-element Delimiter to be used: ☐ Default Delimiter (colon) :

Segment Delimiter to be used: ☐ Default Delimiter (tilde) ~

The Department will provide you with more information at a later date, including a User ID and Password, under separate cover.

All applicants submitting claims or retrieving reports electronically must complete

10 Contact Information

Primary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ (First Name) _____ (Last Name) Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Business email address: _____

Secondary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ (First Name) _____ (Last Name) Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Business email address: _____

EDI Provider Authorization Form

This Authorization must be completed and signed by the provider who wishes to authorize a billing agent, clearinghouse or other provider to:

- *Maintain and control designated reports*
- *Submit and/or retrieve designated transactions*

*The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.*

Provider, _____ hereby appoints
Provider Name (please print)

_____, _____
Billing Agent/Clearinghouse/Provider Name (please print) Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.
Provider must check one box below:

☐ **Provider authorizes the listed agent to retrieve some or all electronic reports/responses on Provider's behalf.**

OR

☐ **Provider does NOT authorize the listed agent to retrieve electronic reports/responses on Provider's behalf.**

_____
Provider/Provider Representative Name (please print)

_____ _____
Provider/Provider Representative Signature Date

_____
Provider Number

This Authorization may be modified or revoked at any time in writing. It is considered in effect until modified or revoked.

This form must be completed by the billing provider <u>not</u> a rendering provider.

Provider Type, Licensure, and Specialty Information

All applicants must complete

11 Provider Type

All applicants must complete. From the list below, identify the provider type (refer to the provider type listing in Appendix A) appropriate to this application. You must complete a separate application for each provider type (check only one box). If you do not find the appropriate provider type on the list below, you may not be eligible to enroll in the Medical Assistance Program at this time. Please call the Medical Assistance Program Provider Services at 1-800-237-0757 for assistance and further directions.

- **Ambulatory Surgical Center (44)** ☐
- **Audiologist (19)** ☐
- **Case Manager (11)** ☐
- **Chiropractor (18)** ☐
- **Clinic**
  - Community Mental Health (35) ☐
  - Developmental Evaluation (46) ☐
  - Family Planning (29) ☐
  - Organized Health (16) ☐
  - Rehab Agency (48) ☐
- **Dental**
  - Dentist (04) ☐
  - Orthodontist (04), Specialty (63) ☐
  - Dental Hygienist (04), Specialty (66) ☐
  - Dental Clinic (47) ☐
- **Developmental Disabilities (HCBS Waiver Services) (36)**
  - *(Select only 1 box in this area)*
  - Children's Habilitative ☐
  - Residential Program (CHRP)
  - HCBS-DD - Group Home Services ☐
  - HCBS DD ☐
    - Children's Extensive Support (CES)
    - Day Habilitation Services
    - Individual Residential Services & Support
    - Supported Living Services (SLS)
- **Dialysis Center (33)** ☐
- **FQHC Freestanding (32)** ☐
- **FQHC Indian Health Services (32)** ☐
- **Home Health (10)** ☐
- **Hospice (50)** ☐
- **Hospital**
  - General (01) ☐
  - Mental (02) ☐
- **Laboratory, Independent (12)** ☐
- **Medicare Crossover Benefits (18)** ☐
- **Mental Health Practitioner**
  - Psychologist PhD Level (37) ☐
  - Less Than PhD Level (38) ☐
    - LCSW, LSW, MFT and LPC
- **Nurse Anesthetist, CRNA (40)** ☐
- **Nurse Midwife (22)** ☐
- **Nurse Practitioner (41)** ☐
- **Nurse, Registered (24)** ☐
- **Nursing Facility**
  - ICF-MR (21) ☐
  - Hospital Back-up Unit (20) ☐
  - Skilled (20) ☐
- **Optician/Optical Outlet (08)** ☐
- **Optometrist (07)** ☐
- **Pharmacy (09)**
  - Pharmacy ☐
  - Mail Order ☐
- **Physician Assistant (39)** ☐
- **Physician**
  - M.D. (05) ☐
  - D.O. (26) ☐
- **Podiatrist (06)** ☐
- **Practitioner Billing Groups**
  - Physician (16) ☐
  - Non-Physician Practitioner (25) ☐
- **Prepaid Health Plan**
  - HMO (23) ☐
  - Mental Health (31) ☐
- **Psychiatric Residential Treatment Facility (30)** ☐
- **Regional Care Coordination Organization (RCCO) (57)** ☐
- **Rural Health Center (45)** ☐
- **School Health Services (51)** ☐
- **Substance Abuse**
  - M.D. (05) ☐
  - Clinic (16) ☐
  - D.O. (26) ☐
  - Psychologist, PhD Level (37) ☐
  - Licensed Mental Health Practitioner (38) ☐
  - Family/Pediatric Nurse Pract (41) ☐
- **Supply/DME (14)** ☐
- **Therapeutic Residential Child Care Facility (TRCCF) (52)** ☐
  - M.D. (05) ☐
  - D.O. (26) ☐
- **Therapeutic Residential Child Care Facility (TRCCF) (52) Cont'd**
  - Psychologist PhD Level (37) ☐
  - MA Psychologist (38) ☐
    - LCSW, LSW, MFT and LPC
  - Physician Assistant (39) ☐
  - Nurse Practitioner (41) ☐
- **Transportation**
  - Ambulance (13) ☐
  - Non-Emergency Transportation (13) ☐
  - Air Ambulance (13) ☐
- **Therapist**
  - Occupational (28) ☐
  - Physical (17) ☐
  - Speech (27) ☐
- **Waiver Services (HCBS) (34)**
  - Adult Day Services ☐
  - Alternative Care Facility ☐
  - Behavioral Programming ☐
  - Behavioral Therapies (Autism) ☐
  - BI Assistive Technology ☐
  - Children's Case Management ☐
  - Community Transition Services ☐
  - Day Treatment ☐
  - In-Home Support Services ☐
  - Independent Living Skills Training ☐
  - Mental Health Counseling ☐
  - **Pediatric Hospice Waiver**
    - Home Health ☐
    - Hospice ☐
    - Personal Care/Homemaker ☐
    - Therapy & Counseling ☐
  - Personal Care/Homemaker ☐
  - Substance Abuse Counseling ☐
  - Supported Living Program ☐
  - Transitional Living Program ☐
  - *(Select 1-3 boxes for the next 3 services listed. Check any that apply.)*
  - 1. Electronic Monitoring ☐
  - 2. Home Modification ☐
  - 3. Non-Medical Transportation ☐
- **X-ray Facility, Freestanding (49)** ☐

12 Licensure

Complete if applicable. Provider types requiring license information are identified in Appendix A. Attach a copy of license(s). Please include copies that contain the original effective date and expiration date.

License No.	License authority /board	Expiration date

Provider Type, Licensure, and Specialty Information - Continued

All applicants must complete

13 Practitioner Specialty Information

All practitioners please complete. If board certified, please provide the specialty board certification number, effective date, *and expiration* of certification. If needed, provide additional information on the reverse or attach additional pages.

Specialty	Certificate Number	Effective	Expiration

Provider Certification and Registration Information

All applicants must complete

14 Malpractice/ General Liability Information

Malpractice/General liability insurance is mandatory under current State and Federal laws

Medical Malpractice/General Liability Insurance Carrier: _____

15 Pharmacy Registration Information

Pharmacy applicants must complete. *Failure to complete this section may affect reimbursement rates.*

National Council on Prescription Drug Programs (NCPDP) number (7 digit number) (Formerly National Association of Board Pharmacies (NABP) number) _____

Pharmacy classification (check one)

- ☐ Metro (independent)
- ☐ Rural (Independent)
- ☐ Hospital
- ☐ Chain
- ☐ Specialty/Infusion
- ☐ State Government
- ☐ 340B
- Federal Government
- ☐ Hospital
- ☐ Retail
- ☐ Mail Order

16 CLIA Registration Information

Applicants who provide laboratory testing services must complete. Enter your *current* CLIA registration number(s). If you do not perform CLIA office testing, you may omit this section. Attach a photocopy of your CLIA certificate that indicates the effective date and the expiration date. (Attach additional pages if necessary.) Note that this information is for CLIA certificates that you **hold**, not for laboratories, etc. that you **use**.

CLIA Number	Certification Type	Effective Date	Expiration Date

Provider Certification and Registration Information - Continued

All applicants must complete

17 Institutional Bed Information

Hospital and Nursing Facility applicants must complete.

Hospitals ➡	Number of Inpatient beds	_____
Nursing Facilities ➡	Number of Skilled Beds	_____
	Number of ICF Beds	_____
ACF ➡	Number of ACF Beds	_____

18 Other Registration Information

Applicants with a Drug Enforcement Agency Number, National Provider Identification Number or a Taxonomy Number must complete. Provide the requested information below.

	Number	Begin Date	End Date
DEA Number ➡			
NPI Number* ➡			
Taxonomy Number* ➡			

*The following provider types are not required to submit an NPI or Taxonomy number: Non-Emergency Transportation, Home & Community Based Services or Waiver providers, Case Management providers, Managed Care Health Plans, & Behavioral Health Organizations. All other provider types need to submit an NPI.

Provider Disclosures

All applicants must complete

Pursuant to federal regulations at 42 CFR §§ 455.104 and 455.106, Providers who are a corporation, limited liability corporation or partnership (disclosing entities) must disclose the information listed under "Legal Name & Business Category". Providers who are sole proprietors must return the form with their names inserted and must indicate (✓) "Sole proprietor". If you are an individual provider, please complete the "Individuals" portion only.

19 Individuals

Please enter your name _____

Have you been convicted of a criminal offense?* ☐ Yes ☐ No

If yes, please explain:
(Attach additional sheets if needed) _____

Legal Name & Business Category

Please enter the legal name of your business _____

and ✓ the business category:

☐ Sole proprietor ☐ Corporation ☐ Government
☐ Partnership ☐ Limited Liability Corporation

Please list the name(s) and address(es) of each person with an ownership or control interest in the Provider or in any subcontractor in which the Provider has direct or indirect ownership of 5% or more. Please indicate whether any of the persons named in one to four below are related to any of the other persons named in one to four below as a spouse, parent, child or sibling. Corporations, LLC, Non-Profits must list Board of Directors in 1-4 below. Government agencies must list local management structure in 1-4 below. Additional space provided on next page.

Person #	Name	Address	City, State, Zip	Relationship to Persons Named in 1 - 4	Convicted of a criminal offense?* Circle One
1.					Yes No
2.					Yes No
3.					Yes No
4.					Yes No

*related to Medicare, Medical Assistance Program or Title XX services program since the inception of those programs.

Provider Disclosures - Continued

All applicants must complete

Please indicate the name of any other disclosing entity in which the persons listed in one through four above also have an ownership or control interest. This requirement applies to the extent that the Provider can obtain this information by requesting it in writing from the person.

_____

_____

_____

_____

_____

This space for fiscal agent use

FA Initial _____ Review Date: _____

Additional Provider Participation Information

All applicants must complete

20 Medicare Participation Information

Complete the information requested below about Medicare participation.

To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.

Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI numbers. If you wish to have assigned Medicare claims cross automatically to the Medical Assistance Program, please list your NPI number(s) in section 18 on page 10. Individuals who are part of a group or clinic should only list their individual numbers, not the group's base number.

☐ **This applicant does not participate in Medicare**

☐ **This applicant does participate in Medicare**

- ☐ Medicare Part A
- ☐ Medicare Part B

Please attach a copy of the Medicare Certification letter.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Medical Assistance Program claims processing system (MMIS).

Medicare numbers are no longer valid for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.

Affiliation Information – Group and Clinic Members

Individual practitioner applicants who will submit claims through a group or clinic must complete.

1. This includes individual physicians working in IHS clinics.
2. Clinic applicants must list all the individuals affiliated to the group or clinic. Groups or Clinics must have at least one enrolled individual affiliated in order to be enrolled with the Colorado Medical Assistance Program.

Please identify each affiliation by name and Medical Assistance Program Provider number. Individual providers cannot bill using a group number that is not listed below. Providers are required to notify Medical Assistance Program Provider Enrollment in writing of any change in affiliation information.

	Name	Medical Assistance Program Provider #
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Signature Authorizations – Request for Original Signature Alternative

Applicants who wish to authorize signatures by others must complete

I authorize and request approval for the following alternatives to an original signature requirement for submission of paper claims to the Colorado Medical Assistance Program.

Rubber stamp facsimile

☐ I authorize the use of a rubber stamp facsimile of my signature to be accepted in place of an original signature. I understand and agree that I am responsible for maintaining control of such a stamp and that the use of the stamp will conform to the requirements of the Colorado Medical Assistance Program. I further understand that I remain fully and totally responsible for the information contained on submitted claims.

➔ **Provider original signature:** _____

Signature stamp facsimile: _____

Authorized agents

☐ I authorize the following individual(s) to sign claim forms submitted to the Colorado Medical Assistance Program as my authorized agent. I understand and agree that any claim forms signed under this authorization constitutes my personal confirmation of services rendered and that I remain solely responsible for the information contained on the claim form. I further understand that this authorization remains in effect until I notify the fiscal agent - in writing - of changes.

➔ **Provider original signature:** _____

	Printed Name of Agent	Original Signature of Agent
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Contact Information

If there are questions concerning this application, who may be contacted if the person submitting the application is not the applicant?

➔ **Contact Name:** _____

Contact Phone Number and/or Email Address: _____

All applicants must complete

Note: All those providers with a current Colorado Medical Assistance Program Provider ID number, or those providers submitting an application to become a Colorado Medical Assistance Program Provider MUST EXECUTE AND RETURN this Provider Participation Agreement.

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is entered into by and between the Colorado Department of Health Care Policy and Financing ("Department"), it's fiscal agent, ACS State Healthcare, LLC ("ACS"), and

_____ , _____ ,
(Provider Name) (Provider Number)

("Provider"), collectively "the Parties." This Agreement is entered into in order to define Department expectations of providers who perform services and submit billing, transactions, and/or data to the Colorado Medical Assistance Program. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. This Agreement is to be considered in conjunction with the Provider Enrollment Form, if necessarily completed.

RECITALS

A. The Colorado Department of Health Care Policy and Financing is the single state agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. ACS has developed, on behalf of the Colorado Department of Health Care Policy and Financing, a paperless transaction system that will process Colorado Medical Assistance Program electronic transactions submitted through the designated electronic media.

C. ACS is the contracted Fiscal Agent for the Colorado Department of Health Care Policy and Financing, which is responsible for administration of the Colorado Medical Assistance Program. Although ACS operates the computer system translator through which electronic transactions flow, the Department retains ownership of the data itself. Providers access the pipeline network through various means, over which the transmission of electronic data occurs. Accordingly, providers are required to transport data to and from ACS.

D. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

E. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

F. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the Colorado Medical Assistance Program. As consideration for acceptance as an enrolled provider in the Colorado Medical Assistance Program, the Provider certifies and agrees to the terms and conditions set forth below.

All applicants must complete

DEFINITIONS

For the purpose of this Agreement:

A. "Colorado Department of Health Care Policy and Financing" means the Colorado State governmental agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. "Standard" is defined in 45 C.F.R. §160.103.

C. "Provider" refers to any health care provider with a current Colorado Medical Assistance Program Provider ID number or any health care provider submitting an application to become a Colorado Medical Assistance Program Provider. "Provider" also includes all agents, subcontractors, or employees of a Colorado Medical Assistance Program Provider.

D. "Transaction" is defined in 45 C.F.R. §160.103.

E. "Transactions and Code Set Regulations" mean those regulations governing the transmission of certain health claims transactions as promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. Parts 160 and 162.

PROVIDER PARTICIPATION

A. Provider will comply with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and Department rules. Provider will limit the use or disclosure of information/data concerning Colorado Medical Assistance Program clients to the purposes directly connected with the administration of the Colorado Medical Assistance Program.

B. Provider will accept full legal responsibility for all claims submitted under the Provider's Colorado Medical Assistance Program ID number to the Colorado Medical Assistance Program and will comply with all federal and state civil and criminal statutes, regulations and rules relating to the delivery of benefits to eligible individuals and to the submission of claims for such benefits. Provider understands that non-compliance could result in no payment for services rendered.

C. Provider will request payment only for those services which are medically necessary or considered covered preventive services, and rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision. Claims will be submitted only for those benefits provided by health care personnel who meet the professional qualifications established by the State. Provider understands that any misrepresentation or falsification by another may result in fine and/or imprisonment under state or federal law.

D. Provider will maintain records that fully and accurately disclose the nature and extent of benefits provided to eligible clients/patients in accordance with the regulations of the Department. Provider will maintain licensure and/or certification granted by the State licensing agency that regulates the services that are provided, and will make disclosure of ownership and provide access to medical records and billing information to the Department, or its designees, as required by federal and state laws and regulations.

E. Provider records will be maintained for six (6) years unless an additional retention period is required under state or federal regulations, such as an audit started before the six (6) year period ended or based on a specific contract between the Provider and the Department.

F. The US Department of Health and Human Services, the Department, or the State Attorney General's Medicaid Fraud Control Unit, or their designees, has the right to audit and confirm for any purpose any information submitted by the Provider. Provider agrees to furnish information about submitted claims, any claim documentation records, and original source documentation; including provider and patient signatures, medical and financial records in the Provider's office or any other place, and any other relevant information upon request. Any and all incorrect payments discovered as a result of an audit will be adjusted or fully recovered according to the applicable provisions of the Social Security Act, as amended, federal or state laws, regulations, and guidelines.

G. Provider agrees to accept as payment in full, amounts paid in accordance with schedules established by the Department. No supplemental charges will be billed to the client, except for amounts designated as co-payments by the Department. Provider will not bill the client for any covered items or services that are reimbursable under the rules and regulations of the Department, or for any items or services that are not reimbursable but would have been had the Provider complied with the rules and regulations of the Department. All payments received or applied from any other sources will be recorded on the claim.

H. Provider certifies that items and services provided will be available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, handicap, or national origin. Provider hereby certifies compliance with Section 504 of the Rehabilitation Act of 1973 which provides that, " no otherwise qualified handicapped individual...shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

I. If, at any time from the date of this agreement, the Department determines that Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, Provider may be suspended from participation in the Medical Assistance Program, and may be subjected to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

J. Department payment by electronic funds transfer (EFT) and advisement by deposit notice or remittance statement represents Provider's confirmation that funds were accepted for services rendered and billed.

K. Provider, and person signing the claim or submitting electronic claims on Provider's behalf, understands that failure to comply with any of the above in a true and accurate manner will result in any available administrative or criminal action available to the Department, the State Attorney General's Medicaid Fraud Control Unit, or other government agencies. The knowing submission of false claims or causing another to submit false claims may subject the persons responsible to criminal charges, civil penalties, and/or forfeitures.

GENERAL ELECTRONIC DATA INTERCHANGE TERMS AND CONDITIONS

(only applicable to those providers submitting and receiving data electronically)

A. The Parties agree to submit claims and exchange data electronically using only those approved Transaction types and formats (versions) as selected by Provider within the Provider Enrollment Form.

B. For electronic claims, Provider will ensure that all required provider and patient signatures, including, where applicable, appropriate signatures on behalf of the patient, and required physician certifications are on file in the Provider's office.

C. Transactions/documents will be transmitted electronically either directly or through a contracted third-party service provider, such as a vendor, billing agent, or clearinghouse. Provider may modify its election to use, not use, or change a third-party service provider by updating the Provider Enrollment Form. Provider will be responsible for the costs of any third-party service provider with which it contracts, and will ensure that any third-party service provider contracted will properly institute and adhere to those procedures reasonably calculated to provide appropriate levels of security for the authorized transmission of data, and protection from improper access. No Party accepts responsibility for technical or operational difficulties that arise out of third-party service providers' business obligations and requirements that undermine the Transaction exchange between Provider and ACS.

D. The Parties will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically, as per 45 C.F.R. §162.915.

E. The Parties will not add any data elements or segments to the maximum defined data set, as per 45 C.F.R. §162.915.

F. The Parties will not use any code or data elements that are either marked "not used" in a standard's implementation specification or are not in the standard's implementation specification(s), as per 45 C.F.R. §162.915.

G. The Parties will not change the meaning or intent of a Standard's implementation specification(s), as per 45 C.F.R. §162.915.

H. ACS will accept Transactions from Provider according to the Provider Enrollment Form, but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the Provider Enrollment Form. ACS may return Provider to a test status if Provider repeatedly submits Transactions that do not meet the criteria set forth in the Provider Enrollment Form or if Provider repeatedly submits inaccurate or incomplete Transactions to ACS.

I. Provider understands that ACS or others may request an exception from the Transaction and Code Set Regulations from the U.S. Department of Health and Human Services. If an exception is granted, Provider will participate fully with ACS in the testing, verification, and implementation of a modification to a Transaction affected by the change.

J. Provider and ACS agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer, as per 45 C.F.R. §162.925(c)(2).

K. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving Party. Once transmissions are properly received, the receiving Party will promptly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received Transactions. Each Party will subject information to a virus check before transmission to the other Party.

L. ACS may publish data clarifications ("Companion Guides") to complement each Implementation Guide. HIPAA Implementation Guides are available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Companion Guides are available on the Department's Web site at colorado.gov/hcpf➡Providers➡Provider Services➡Specifications.

ELECTRONIC CONFIDENTIALITY, PRIVACY AND SECURITY

(only applicable to those providers submitting and receiving data electronically)

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Regulations (45 C.F.R. Parts 160 and 164) apply to all health plans, health care clearinghouses, and health care providers that transmit protected health information in electronic transactions; and extends to any business associate working on behalf of a covered entity. As such, it is expected that all Parties will implement and maintain appropriate policies, procedures, and mechanisms to protect the privacy and security of protected health information that is maintained by, and transmitted between, the Parties.

B. The Parties agree that any electronic protected health information furnished to one Party by any other Party will be used only as authorized under the terms and conditions of this Agreement and the Provider Enrollment Form, and may not be further disclosed. The Parties will establish appropriate administrative, technical, procedural, and physical safeguards to ensure the confidentiality, integrity, and availability of all electronic protected health information that is created, received, maintained, or transmitted as part of this Agreement. Provider will obtain satisfactory assurance and documentation thereof, as required by 45 C.F.R. §164.502(e), from any business associate with whom it contracts, and any subcontractors thereof, that all protected health information covered by this Agreement will be appropriately safeguarded.

C. Provider agrees that in the event the Department determines, or has a reasonable belief that Provider has made or may have made disclosure of Colorado Medical Assistance Program client protected health information that is not authorized by this Agreement, the Provider Enrollment Form, or other written Department authorization, the Department, in its sole discretion, may require ACS and/or Provider to: (a) promptly investigate and report to the Department determinations regarding any alleged or actual unauthorized disclosure; (b) promptly resolve any problems identified by the investigation; (c) submit a formal written response to an allegation of unauthorized disclosure; (d) submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and/or (e) return data to the Department.

ASSIGNMENT OF AGREEMENT

A. This Agreement is entered into solely between, and may be enforced only by the Parties. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of the Parties to any third party.

B. No Party may assign this Agreement without the prior written consent of the Department, and such consent may not be unreasonably withheld.

MODIFICATIONS

A. This Agreement contains the entire agreement between the Parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information/data. Any change to this Agreement will be effective only when set forth in writing and executed by all Parties.

DISPUTES AND LIMITATION OF LIABILITY

A. This Agreement will be interpreted consistently with all applicable federal and state laws. In the event of a conflict between applicable laws, the more stringent law will be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement will be governed by and construed in accordance with Colorado law, exclusive of conflicts of law principles. The exclusive jurisdiction for any legal proceeding regarding this agreement shall be in the courts of the State of Colorado and the Parties hereby expressly submit to such jurisdiction.

B. Parties will use reasonable efforts to assure that the information – data, electronic files and documents supplied hereunder – are accurate. However, Provider shall indemnify, save, and hold harmless the Department, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the Provider, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement

C. Notwithstanding anything herein to the contrary, no term or condition shall be deemed, construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or provisions, of the "Colorado Governmental Immunity Act", 24-10-101, et seq., C.R.S., as now or hereafter amended ("Immunity Act"), nor of the Risk Management self-insurance statutes at 24-30-1501, et seq., C.R.S., as now or hereafter amended ("Risk Management Act"). The Parties understand and agree that the liability of the State of Colorado, its departments, institutions, agencies, boards, officials and employees is controlled and limited by the provisions of the Immunity Act and the Risk Management Act, as now or hereafter amended. Any provision of this Agreement, whether or not incorporated herein by reference, shall be controlled, limited, and otherwise modified so as to limit any liability of the State to the above cited laws. In no event will the State be liable for any special, indirect, or consequential damages, even if the State has been advised of the possibility thereof.

D. DISCLAIMER OF WARRANTIES. THE PARTIES HEREBY EXCLUDE ALL EXPRESS AND IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY AND THE IMPLIED WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE. THERE ARE NO WARRANTIES WHICH EXTEND BEYOND THE DESCRIPTION OF THE FACE OF THIS AGREEMENT.

E. Provider warrants and represents that at the time of entering into this Agreement, neither Provider nor any of its employees, contractors, subcontractors or agents are identified on the HHS/OIG List of Excluded Individuals/Entities (available at http://www.oig.hhs.gov/FRAUD/exclusions/listofexcluded.html). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to immediately notify the Department of such ineligible person status and within ten days of such notice, remove such individual from responsibility for, or involvement with the Providers business operations related to this Agreement.

TERMINATION

A. This Agreement shall remain in effect until terminated by any Party with not less than thirty (30) days prior written notice to the other Parties. Such notice shall specify the effective date of termination. In the event of a material breach of this Agreement by Provider, as determined by the Department, the Department may terminate the Agreement by giving written notice to the breaching Provider. The breaching Provider shall have thirty (30) days to fully cure the breach. If the breach is not cured within thirty (30) days after the written notice is received by the breaching Provider, this Agreement shall automatically and immediately terminate.

B. This Agreement may be terminated by the Department if the contract between the Department and ACS expires or terminates. Provider enrollment records will survive assignment of a new Department fiscal agent unless provider re-enrollment is explicitly initiated by the Department.

TERM OF AGREEMENT

A. This Agreement is effective for the entire term of enrollment. This Agreement shall continue until terminated.

All applicants must complete

PROVIDER SIGNATURE PAGE

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE

I certify by my signature below that I am fully authorized to sign and execute this Agreement on behalf of Provider; and that I have read, understand, certify, and agree to all the statements made above in all parts of this Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a Colorado Medical Assistance Program Provider, and/or may be prosecuted under applicable federal and state laws.

Provider

By: _____
Provider/Provider Representative Signature

(If the provider is an Intermediate Care Facility for the Mentally Retarded (ICF/MR), by signing, the ICF/MR also agrees to the stipulations in the addendum on the following page.)

Name: _____
Provider/Provider Representative Name (please print)

Title: _____

Provider #: _____

Date: _____

Only ICF/MR applicants/providers must complete this page

Addendum for Intermediate Care Facility for the Mentally Retarded (ICF/MR) ONLY

For Department of Health Care Policy and Financing staff only:

For an Intermediate Care Facility for the Mentally Retarded (ICF/MR) provider, the length and conditions of this agreement are assigned by the Department of Health Care Policy and Financing in accordance with 42 C.F.R. Sections 442.12, 442.15(a), 442.16, 442.105, 442.109, and 442.110; and Centers for Medicare and Medicaid Services (CMS) Manual 11-107, State Operations Manual (SOM), Section 2141. Based on survey results, the status of certification and/or recommendations by the Department of Public Health and Environment (DPHE), and criteria in the cited federal regulations and SOM, the Department has determined the conditions of the agreement as specified in one of the following blocks:

This agreement shall commence on _____ and terminate on _____

OR (only for ICF/MR provider with deficiencies but in compliance with survey Conditions of Participation)

This agreement shall commence on _____ and terminate on _____, subject to automatic cancellation 60 days after the projected correction date in the Plan of Correction (PoC) accepted by DPHE for the deficiencies identified by DPHE in the most recent survey prior to the commencement date. Automatic cancellation shall occur if all deficiencies are not corrected, unless the Department and DPHE in their sole discretion determine that the ICF/MR has made substantial effort and progress in correcting deficiencies. This determination is not subject to appeal.
Date of most recent survey prior to commencement date: _____
Projected completion date of Plan of Correction: _____
Automatic cancellation date (60 days after projected completion of PoC) _____

Provider

By: _____
ICF/MR Provider/Provider Representative Signature

Name: _____
ICF/MR Provider/Provider Representative Name (please print)

Title: _____

Provider #: _____

Date: _____

Payment Reporting and Publication Email Preference

All applicants must complete

Provider Claim Report (PCR) Information

The following information will allow the Colorado Medical Assistance Program to prepare your PCR in a manner that is helpful for you. Please indicate your preferences.

☐ My claims will be submitted by (through) another provider who will receive the PCRs and payments. (Skip remaining Provider Claim Report questions - **No start-up Billing Packet will be sent**.)

Sort sequence preference

In what order do you want claims listed on the PCR? If no selection is made, claims will be sorted in order by client last name.

☐ Client last name (N)
☐ Date of Service (D)
☐ Client State Medical Assistance Program ID (I)
☐ Patient account/Invoice number (A)
☐ Rendering Provider Number (B) (may be useful for group practices)
☐ Rendering Provider Name (P) (may be useful for group practices)

Reporting in process (suspended) claims

How do you want in-process (suspended) claims reported on the PCR? If no selection is made all suspended claims will be listed.

☐ List all suspended claims (A)
☐ List only new suspended claim (O)
☐ Do not list suspended claims (N) (not recommended)

Publication Email Notification Preference

The Colorado Medical Assistance Program communicates important notices (including time-sensitive information), updates, billing instructions and bulletin links via email as soon as the information is available. *Providers are responsible for ensuring that the fiscal agent has their current email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.*

All publications are available in the Provider Services section of the Department's Web site at colorado.gov/hcpf.

Publication Email Notification Preference *(Please check one)**:***

☐ Please email notifications and bulletin links to me.

☐ Another provider will receive email notifications and bulletin links on my behalf. *(I understand that I am responsible for obtaining the information from this provider and that I will **not** receive any email notifications from the Colorado Medical Assistance Program).*

☐ None *(I understand that I am responsible for retrieving publications from the Web site and that I will **not** receive any email notifications from the Colorado Medical Assistance Program).*

Provider Email Address: _____

*Please note that only **one** email address per provider may be on file.*

Please return the completed Provider Enrollment Form, Provider Authorization Form (if applicable), and executed Provider Participation Agreement to the following address:

ACS State Healthcare
Colorado Medical Assistance Program
Provider Services
P.O. Box 1100
Denver, CO 80201-1100

Practitioners and Practitioner Groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual practitioners must complete a provider application and be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have a group provider number. The group provider number must be identified as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Certified Nurse-Midwife (22)	Attach state nursing license and certificate from American College of Nurse-Midwives.
Clinic, Professional Corporation, Partnership, or Sole Proprietorship (16)	At least one Medical Assistance Program-enrolled practitioner must be listed. Requires CLIA certificate for laboratory services if applicable.
Optometrist (07)	Attach state optometry license.
Physician (MD) (05) and (DO) (26)	Attach state medical license and specialty certification if applicable. Requires CLIA certificate for laboratory services if applicable.
Podiatrist (06)	Attach state podiatry license. Requires CLIA certificate for laboratory services if applicable.
Non-Physician Practitioner Group (25)	At least one Medical Assistance Program-enrolled non-physician practitioner must be listed.

Non-Physician Practitioners - Requiring on-premise physician supervision

Requires on-premise physician supervision when services are provided and payments must be made to a physician or clinic. Must identify physician supervisor by name on the separate "Non-Physician practitioners requiring on-premise physician supervision" form.

Services/Providers	Licensure & certification submission requirements
Registered Nurse (24)	Attach state nursing license.

Non-physician Practitioners - Special direct payment requirements

By enrolling for direct payment you are certifying that services are not provided in the course of employment, otherwise payments must be made to a physician or clinic.

Services/Providers	Licensure & certification submission requirements
Audiologist (19)	Attach copy of Colorado Audiology License Certification from the American Speech and Health Association or the American Board of Audiology. Proof of registration with State Audiology and Hearing Aid Provider Registration Office. If providing services in the course of employment, payments must be made to a physician or clinic.
Certified Registered Nurse Anesthetist (40)	Attach state nursing license and certification by the Council on Nurse Anesthetists. If providing services in the course of employment, payments must be made to a physician or clinic.
Doctorate Level Psychologist (37)	Licensed: Attach Colorado Psychologist License. Unlicensed: Cannot enroll.
Licensed Mental Health Professional (under Doctorate Level) (38)	Attach state social work license or professional counselor license and proof of education. If providing services in the course of employment, payments must be made to a physician or clinic.

Non-Physician Practitioners - Special direct payment requirements

By enrolling for direct payment you are certifying that services are not provided in the course of employment, otherwise payments must be made to a physician or clinic.

Services/Providers	Licensure & certification submission requirements
Nurse Practitioner (41)	Attach State Nursing License + one of the following: Pediatric Nurse Practitioner Certificate from National Certification Board of Pediatric Nurse Practitioners or Family Nurse Practitioner Certificate from American Nurse Association. If providing services in the course of employment, payments must be made to a physician or clinic.
Occupational Therapist (28)	Attach state occupational therapy license. If providing services in the course of employment, payments must be made to a physician or clinic.
Physical Therapist (17)	Attach State physical therapy license. If providing services outside the course of employment only general physician supervision is required. If providing services in the course of employment, payments must be made to a physician or clinic.
Physician Assistant (39)	Attach state medical license. If providing services outside the course of employment only general physician supervision is required. If providing services in the course of employment, payments must be made to a physician or clinic.
Speech Therapist (27)	Attach American Speech and Hearing Association certification. If providing services in the course of employment, payments must be made to a physician or clinic.

Dental providers and dental groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual dental providers must be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have a group provider number. All claims must identify the group provider number as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Dental Clinic, Professional Corporation, Partnership, or Sole Proprietorship (47)	Dental clinic ownership must be a licensed dentist or dental hygienist, a political subdivision, or a non-profit corporation. In state dental clinic owners must have a current/active/valid Colorado dental or dental hygienist license. Attach a copy of the license. A non-profit corporation must be in good standing and submit a copy of the Certification of Good Standing issued by the Colorado Secretary of State. At least one Medical Assistance Program enrolled dentist or dental hygienist must be associated with the clinic. Attach a copy of the dental license.
Dentist (04)	Attach a copy of state dental license.
Orthodontist (04), Specialty (63)	Attach a copy of state dental license and certificate of graduation from an American Dental Association Accreditation Commission accredited program in orthodontics.

Dental providers with special direct payment requirements

Licensed dental hygienists shall be directly reimbursed for unsupervised dental hygiene services rendered to Medical Assistance Program enrolled children effective February 1, 2002. Those licensed dental hygienists requesting direct reimbursement must complete a provider enrollment form. The dental hygienist employed by a dentist, clinic or institution shall not submit claims individually and shall submit claims under the employer's assigned Medical Assistance Program provider number.

Dental Hygienist (04), Specialty (66)	Attach a copy of state dental hygiene license

Medical Services Facilities (other than nursing facilities)

Services/Providers	Licensure & certification submission requirements
Ambulatory Surgical Center (44)	Attach state license, and certificate (Department of Public Health and Environment) and Medicare certification.
Hospital, General (01) and Mental (02)	Attach state license, certificate (Department of Public Health and Environment), Medicare certification, CLIA certification and proof of liability/fidelity insurance. In- state hospitals require contract with Colorado Department of Health Care Policy and Financing.

Medical Services Facilities (other than nursing facilities)

Services/Providers	Licensure & certification submission requirements
Independent Laboratory (12)	Attach CLIA certification (Department of Public Health & Environment) and Medicare certification.
X-ray Facility (Freestanding) (49)	Attach state Certification and Evaluation Report (Department of Public Health and Environment), American College of Radiology certificate and American Registry of Radiologic Technologists certificate, and Medicare certification. Mammography providers must also attach Mammography Quality Standards Act certification and US Department of Health and Human Services survey approval.

Nursing and Residential Facilities

Services/Providers	Licensure & certification submission requirements
Intermediate Nursing Facility (21)	Attach state license (Department of Public Health & Environment). Requires contract with Colorado Department of Health Care Policy and Financing.
Skilled Nursing Facility (20)	Attach state license and certificate (Department of Public Health and Environment). Requires contract with Colorado Department of Health Care Policy and Financing. Medicare certification required for Swing Bed facilities.
Psychiatric Residential Treatment Facility (30)	Attach State license (Department of Human Services) and DPHE certification.
Therapeutic Residential Child Care Facility (52)	Attach State license (Department of Human Services).
Physician (MD) (05) and (DO) (26)	*Attach state medical license and specialty certification if applicable. Requires CLIA certificate for laboratory services if applicable.*
Doctorate Level Psychologist (37)	*Attach state Psychologist License.*
MA Psychologist (38) (under Doctorate Level)	*Attach state clinical social worker license, marriage and family therapist license or professional counselor license.*
	(On premise physician supervision is waived for mental health professionals providing mental health services in Therapeutic Residential Child Care Facilities)
Physician Assistant (39)	*Attach State medical license.*
Nurse Practitioner (41)	*Attach State Nursing License and documentation of registration as an advance practice nurse with prescriptive authority.*
	If providing services in the course of employment, payments must be made to a physician or clinic.

Prepaid Health Plan Providers

Services/Providers	Licensure & certification submission requirements
Contracted Health Maintenance Organization or Prepaid Health Plan (capitation) (23)	Requires contract with Colorado Department of Health Care Policy and Financing. Attach state license (Division of Insurance).
Contracted Mental Health Assessment and Service Agency (capitation) (31)	Requires contract with Colorado Department of Health Care Policy and Financing. Attach state license (Division of Insurance).

Clinics, Agencies and Specialized Services Providers

Services/Providers	Licensure & certification submission requirements
Community Mental Health Center (35)	Attach state license (Department of Public Health and Environment) and certificate. Requires contract with Colorado Department of Health Care Policy and Financing.
Certified Public Health Clinic (16)	Attach state license (Department of Public Health and Environment). Note: Individual service providers (nurses and nurse practitioners) and the agency's medical director (physician) must be enrolled.
Contracted Family Planning Clinic (29)	Attach state license (Department of Public Health & Environment). Requires contract with Colorado Department of Health Care Policy and Financing. Individual service providers (nurses and nurse practitioners) must be enrolled.

Clinics, Agencies and Specialized Services Providers

Services/Providers	Licensure & certification submission requirements
Federally Qualified Health Center (32)	Attach state license (Department of Public Health and Environment). Approval letter from US Department of Health and Human Services or CMS, and Medicare certification. Note: Individual service providers (nurses and nurse practitioners) and the agency's medical director (physician) must be enrolled.
Home Health Agency (10)	Attach state certificate (Department of Public Health and Environment) and Medicare certification specifically for Home Health.
Dialysis Center (33)	Attach state license and certificate (Department of Public Health and Environment) and Medicare certification.
Developmental Evaluation Clinic (46)	Attach state license and certificate (Department of Public Health and Environment). Individual service providers must be enrolled.
Hospice (50)	Attach state license and certificate (Department of Public Health & Environment) and Medicare certification.
Rural Health Clinic (45)	Attach state license (Department of Public Health & Environment), Medicare certification (indicating Freestanding) and rate sheet. Note: Individual service providers (nurses and nurse practitioners) and the agency's medical director (physician) must be enrolled.
Rehab Agency (48)	Attach state certificate (Department of Public Health and Environment) and Medicare certification (optional). Individual service providers must be enrolled.

Retail Providers

Services/Providers	Licensure & certification submission requirements
Optical Office (Optician) (08)	Attach business license (sales tax certificate).
Oxygen Supplier for Nursing Facilities (14)	Enroll as a Supply provider.
Pharmacy (09)	Attach State pharmacy license and National Council of Prescription Drug Programs certificate.
Supply/Medical Equipment Supplier (14)	Attach business license (sales tax certificate). Medicare Accreditation Certificate or letter required, attach copy.

Providers enrolled for Medicare crossover benefits only

Services/Providers	Licensure & certification submission requirements
Chiropractor (18)	Attach current State chiropractic license and proof of Medicare participation.
Non-Physician Mammography Practitioners (18)	Attach US Department of Health & Human Services, or CMS certification and registration by the American Registry of Radiologic Technologists or American College of Radiology, and proof of Medicare participation.

Community Based Services Providers

Services/Providers	Licensure & certification submission requirements
Community-based Services for the Elderly, Blind, Disabled, Mentally Ill, Persons Living With AIDS, Children's Home and Community Based Services, etc. (34)	Attach state license (Department of Public Health & Environment), when applicable. Enrollment requires approval from the Colorado Department of Health Care Policy and Financing.

Community Based Services Providers

Services/Providers	Licensure & certification submission requirements
Community Services for the Developmentally Disabled (36)	Attach state license (Department of Public Health & Environment), when applicable. Enrollment requires approval from the Colorado Department of Human Services, Division of Developmental Disabilities.
School District (51)	

Transportation Providers

Services/Providers	Licensure & certification submission requirements
Emergency Transportation (13)	Attach County ambulance permit and Medicare certification.
Non-Emergency Transportation (13)	Attach Public Utilities Commission certificate.
Air Transportation (13)	Attach licensed accreditation from DPHE pursuant to CRS §25.23.5-307. Attach Accreditation of Medical Transport Systems (CAMTS).

Substitute Form
W-9

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER (TIN) VERIFICATION

State of Colorado
Do NOT send to IRS

PRINT OR TYPE

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SOCIAL SECURITY ADMINISTRATION RECORDS)
DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE - See Reverse for Important Information

Trade Name COMPLETE ONLY IF DOING BUSINESS AS (D/B/A)

Remit Address

Purchase Order Address – Optional

RETURN TO ADDRESS BELOW

PART II See Part II Instructions on Back of Form

Check legal entity type and enter 9 digit Taxpayer Identification Number (TIN) below:
(SSN = Social Security Number EIN = Employer Identification Number)

Do Not enter an SSN or EIN that was not assigned to the legal name entered above.

☐ **Individual** (Individual's SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
NOTE: If no name is circled on a Joint Account when there is more than one name, the number will be considered to be that of the first name listed.

☐ **Sole Proprietorship** (Owner's SSN or Business FEIN)
NOTE: Enter both the owner's SSN and the business EIN (if you are required to have one)
SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
EIN ___ ___ - ___ ___ ___ ___ ___ ___ ___

☐ **Partnership** ☐ General ☐ Limited (Partnership's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___

☐ **Estate / Trust** (Legal Entity's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
NOTE: Do not furnish the identification number of personal representative or trustee unless the legal entity itself is not designated in the account title. List and circle the name of the legal trust, estate or pension trust.

☐ **Other** ▶ _____ (Entity's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
Limited Liability Company, Joint Venture, Club, etc.

☐ **Corporation** Do you provide legal or medical services? ☐ Yes ☐ No (Corp's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
Includes corporations providing medical billing services

☐ **Government** (or Government Operated) Enity (Entity's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___

☐ **Organization Exempt from Tax under Section 501(a)** (Org's EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
Do you provide medical services? ☐ Yes ☐ No

☐ Check Here if you do not have a SSN or EIN, but have applied for one. See reverse for information on How to Obtain A TIN.
Licensed Real Estate Broker? ☐ Yes ☐ No

Under Penalties of perjury, I certify that:

(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends' or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition of abandonment of secured property, contribution to an individual retirement arrangement (IPA), and payments other than interest and dividends).

CERTIFICATION INSTRUCTIONS – You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return. (See Signing the Certification on the reverse of this form.)

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING

NAME (Print or Type) _____ TITLE (Print or Type) _____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE (_____) _____

DO NOT WRITE BELOW THIS LINE **RETURN BOTH COPIES TO ADDRESS ABOVE**

AGENCY USE ONLY

Agency ___ ___ ___ Approved By _____ Date _____
1099 Y ___ N ___
VEND Addition ___ Change ___ Action Completed By _____ Date _____

615-82-50-7093 (R 11/98)

Back of W-9 – Completion Instructions

PART I — NAME AND TAX IDENTIFICATION NUMBER (TIN)

INDIVIDUALS: Enter First and Last name EXACTLY as it appears on your Social Security Card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name and both the last name shown on your Social Security Card and your new last name (IN THAT ORDER). For your TIN, enter your Social Security Number (SSN).

SOLE PROPRIETORSHIPS: Enter the owner's name on the first line; on the second line you may enter the business name. YOU MAY NOT ENTER ONLY THE BUSINESS NAME. For the TIN, enter both the owner's Social Security Number and the Federal Employer Tax Identification Number (EIN) if you are required to have one.

ALL OTHER ENTITIES: Enter the name of the owner of the EIN or SSN exactly as originally registered with the IRS. The correct TIN is the Employer Identification Number (EIN).

DO NOT ENTER AN SSN OR EIN THAT WAS NOT ASSIGNED TO THE LEGAL NAME ON THIS FORM

HOW TO OBTAIN A TIN

If you do not have a TIN, you should apply for one immediately. To apply for the number, obtain Form SS-05, Application for a Social Security Number Card (for individuals), or Form SS-4, Application of Employer Identification Number (for businesses and all entities), at your local office of the Social Security Administration or the Internal Revenue Service. Complete and file the appropriate form according to its instructions.

To complete Form W-9 if you do not have a TIN, check "Applied For" box in the space indicated on the front, sign and date the form, and give it to the requester. For payments that could be subject to backup withholding, you will then have 60 days to obtain a TIN and furnish it to the requester. During the 60-day period, the payments you receive will not be subject to the 31% backup withholding, unless you make a withdrawal. However if the requester does dot receive your TIN from you within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the requester.

Note: *Writing "Applied For" on the form means that you have already applied for a TIN OR that you intend to apply for one in the near future.*

As soon as you receive your TIN, complete another W-9, include your new TIN, sign and date the form, and give it to the requester.

PART II — FOR PAYEES EXEMPT FROM BACKUP WITHHOLDING

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write 'Exempt' in Part II, and sign and date the form.

If you are a nonresident alien or foreign entity not subject to backup withholding, give the requester a completed Form W-8, Certificate of Foreign Status.

PART III — CERTIFICATION

(1) **Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts That Were Considered Active During 1983.**
- You are not required to sign the certification; however, you may do so. You are required to provide your correct TIN.

(2) **Interest, Dividend, Broker and Barter Exchange Accounts Opened After 1983 and Broker Accounts That Were Considered Inactive During 1983.**
- You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item (2) in the certification before signing the form.

(3) **Real Estate Transactions** – You must sign the certification. You may cross out item (2) of the certification if you wish.

(4) **Other Payments** – You are required to furnish your correct TIN, but you are not required to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a non-employee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

(5) **Mortgage Interest Paid by You, Acquisition or Abandonment of secured Property, or IRA Contributions.** – You are required to furnish your correct TIN, but you are not required to sign the certification.

OTHER

Signature. – The signature should be an authorized signature, generally the person whose name is on the top line of the form, a partner in the partnership, or an officer of the corporation. For a joint account, only the person who's TIN is shown in LEGAL BUSINESS DESIGNATION should sign the form.

Privacy Act Notice. – Section 6109 requires you to furnish your correct taxpayer identification number (TIN) to persons who must file information returns with IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain other penalties may also apply.

Agency ID UHA

State of Colorado

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one:

New ☐ **Change** ☐

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** _____

LEGAL NAME _____

DBA NAME _____

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER
(Corporation, partnership, trust, sole proprietor, etc.) ____ ____ - ____ ____ ____ ____ ____ ____ ____

or

SOCIAL SECURITY NUMBER (Individual or sole proprietor) ____ ____ ____ - ____ ____ - ____ ____ ____ ____

ADDRESS _____

CITY, STATE, ZIP _____

DEPOSITORY INFORMATION

BANK NAME _____

BANK ADDRESS _____

CITY, STATE, ZIP _____

BANK DEPOSITORY TRANSIT NUMBER _____

ACCOUNT NUMBER _____

TYPE OF BANK ACCOUNT (CHECK ONE) ☐ CHECKING ☐ SAVINGS

Attach voided check or bank letter ***Attach bank letter***

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it.
It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date _____ Phone number _____

Authorized Signature _____

Title _____

Authorized Signature _____

Title _____

For Fiscal Agent Use Only *Initials:* _____ *Date:* _____

Revised: November 2010g

Completion Instructions

Agency ID UHA

State of Colorado
AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one: **New** ☐ **Change** ☐

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** *Enter your 8-digit provider #*

LEGAL NAME *Enter the legal name assigned to the Federal EIN or SSN below*

DBA NAME *Optional – You may enter the DBA or trade name for corporation, sole proprietor, etc.*

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER (Corporation, partnership, trust, sole proprietor, etc.) *Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.*

or

SOCIAL SECURITY NUMBER (Individual or sole proprietor) *Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above.*

ADDRESS *Enter the mailing address for the legal name entered above*

CITY, STATE, ZIP *Enter the City, State and ZIP for the legal name entered above*

DEPOSITORY INFORMATION

BANK NAME *Enter the name of the bank or financial institution where the funds will be transferred*

BANK ADDRESS *Enter the address of the bank or financial institution*

CITY, STATE, ZIP *Enter the City, State and ZIP for the bank or financial institution*

BANK DEPOSITORY TRANSIT NUMBER *Enter the 9-digit number from your voided check (see illustration below) or contact your financial institution for information*

ACCOUNT NUMBER *Enter the account number where the funds will be deposited*

TYPE OF BANK ACCOUNT (CHECK ONE) ☐ CHECKING ***Attach voided check or bank letter*** ☐ SAVINGS ***Attach bank letter***

Enter a check mark to identify the type of account where the funds will be deposited.

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it.
It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date *Enter the date the form is signed* Phone number *Enter your telephone number*

Authorized Signature *This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.*

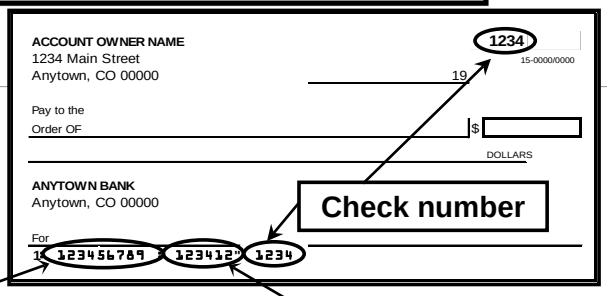
Title *Enter the title of the authorized representative of a corporation, partnership, etc.*

Authorized Signature *Optional – Add a second signature only if required for a corporation, partnership, etc.*

Title *Enter the title of the second authorized representative of a corporation, partnership, etc.*

For Fiscal Agent Use Only *Initials:* _____ *Date:* _____

Revised: February 2009



Account Number Illustration

Please note: The completed EFT form must be submitted ***with*** a completed W-9.
Please allow 30 days to process your paperwork and establish your EFT.

Colorado Medical Assistance Program
Provider Services
P.O. Box 1100
Denver, CO 80201-1100

FISCAL AGENT FOR
The Colorado Medical Assistance Program
ACS
A xerox Company

1-800-237-0757
Fax: 303-534-0439

Colorado Medical Assistance Program billing information is available on the Department's Web site at:

colorado.gov/hcpf➡Providers➡Provider Services➡Billing Manuals

And Bulletins are available on the Department's Web site at:

colorado.gov/hcpf➡Providers➡Provider Services➡Bulletins

If you are part of an organization that already bills the Colorado Medical Assistance Program or if you want to access billing information online, no further action is required.

Thank you for submitting an enrollment application to the Colorado Medical Assistance Program.

If you would like a Billing Packet CD, please check below:

☐ **Please send me a Colorado Medical Assistance Program Billing Packet CD.**

(Please return with your application.)